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Informing patients: The *Bolam* legacy

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Abstract

In the context of medical advice to patients, the UK decision in *Montgomery v. Lanarkshire Health Board* rejected the application of *Bolam v. Friern Hospital Management Committee*. This article argues that the rejection is neither complete nor settled. We explore doctrinal, conceptual and practical limitations of *Montgomery* to demonstrate the vestiges of *Bolam*'s relevance to medical advice. Medical advice does not end with disclosure of material risk but incorporates information on prognosis, diagnosis and treatment alternatives. *Montgomery* does not always apply in these cases, nor outside the medical mainstream or where patients lack capacity to consent. We identify ways in which the extension of patient-centred care in the giving of medical advice can be achieved through incremental development of *Montgomery* and application of the *Bolitho* gloss to require that processes conform to *Montgomery* principles of partnership and autonomy.

Keywords

Bolam, disclosure of risk, informed consent, *Montgomery*, negligence

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Introduction

For some time, the non-disclosure of information to patients in England and Wales was governed by *Bolam v. Friern Hospital Management Committee* (*Bolam*), a highly influential first instance decision which set out the standard of care for skilled professionals applied in relation to both treatment/diagnosis and the giving of advice about risks

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inherent in medical treatment.¹ In 2015, the UK Supreme Court in *Montgomery v. Lanarkshire Health Board* (*Montgomery*) held that *Bolam* should no longer apply in the context of negligent non-disclosure of information about risks and reasonable treatment alternatives.² Lords Kerr and Reed, who jointly gave the leading judgment, stated: ‘There is no reason to perpetuate the application of the *Bolam* test in this context any longer’.³ In this article, we expose *Bolam*’s ongoing legacy in relation to aspects of healthcare professionals’ (HCPs’) advisory role. We suggest ways in which legal developments might mitigate issues flowing from the dual application of *Bolam* and *Montgomery* in different aspects of HCPs’ advisory role and endorse a patient-centred approach to medical advice that applies beyond negligent non-disclosure of information.

In ‘The *Bolam* identity’⁴ and ‘The *Bolam* betrayal’, we briefly set out the *Bolam* decision, its expansion and subsequent attempts to apply judicial controls, particularly in relation to non-disclosure of information in the case of *Montgomery*. The next sections set out new arguments as to *Bolam*’s legacy from two perspectives. We begin with a doctrinal examination of *Bolam*’s current relevance. While *Montgomery* enhances commitment to patient values, it also (rightly we would argue) recognises the pertinence of clinical expertise, and with it, the relevance of *Bolam*. In ‘The *Bolam* retribution’, we argue that the dissection of the duty of care established in *Montgomery* is neither settled nor clear. We derive three explanations from *Montgomery* for the respective relevance of *Bolam* and *Montgomery* tests and show that they can conflict. The next section considers *Bolam*’s legacy beyond negligence. In ‘The *Montgomery* enigma’, we criticise the consumeristic conception of patient choice alluded to in *Montgomery*. We consider the inherent limitations of *Montgomery* given its focus on material risk which relates to but one of many aspects of the HCP advisory role, and set out practical challenges in its application. We set out a normative argument for the development of a better appreciation of the role of partnership in both treatment selection and choice between treatments. In the final section – the ‘*Montgomery* supremacy’ – we consider the potential for *Montgomery*’s incremental legal development and influence.

Montgomery is a landmark decision and adoption of its principles within and beyond clinical negligence has potential to transform clinical practice. However, while *Bolam*’s influence has declined, we point to its continued relevance in various aspects of clinical advice, and while *Montgomery* represents a watershed, there are barriers to the proliferation of its principles beyond clinical negligence. In working to overcome these challenges, we emphasise the importance of balancing patient values with professional expertise and set out ways in which that might be achieved.

1. *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583. And see Scottish case *Hunter v. Hanley* [1955] SLT 312.
2. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [2014] 2 All ER 1031, [86]–[87] (per Lords Kerr and Reed unless otherwise stated). See M. Brazier and E. Cave, *Medicine, Patients and the Law* (Manchester: MUP, 2016), 5.8.
3. *Montgomery*, op. cit., [86].
4. The headings used in this article mirror the Bourne series by bestselling author Robert Ludlum, and subsequently Eric van Lustbader.

The *Bolam* identity

Mr Bolam agreed to undergo electroconvulsive therapy to treat his mental illness but sued in negligence when he suffered injury. He complained that he should have been given relaxants and restrained to reduce the risk of physical injury, and also that he should have been warned of the risks. McNair J set out the test for assessing the standard of care in negligence cases involving skilled professionals:

[H]e is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in this particular art.⁵

The result is that, where skilled professionals reach the standard of a responsible body of opinion, they will not be found negligent merely because other skilled professionals would have acted differently. Applying the test in *Bolam*, expert evidence established that medical opinion was opposed to both relaxants and restraints. Furthermore, it was accepted practice not to warn of small risks unless the patient specifically asked. The jury (as the case was then decided) did not establish negligence in relation to either the treatment or the non-disclosure of information as to risk.

In relation to non-disclosure of risk, the relevance of the *Bolam* test was reconsidered in *Sidaway v. Board of Governors of the Bethlem Royal Hospital (Sidaway)*.⁶ Should errors regarding disclosure of information be viewed in the same way as errors in the operating theatre? The judgments in *Sidaway* varied in approach,⁷ with Lord Diplock siding firmly with application of the *Bolam* test, Lord Scarman embracing a more patient-centred approach and Lord Bridge of Harwich (with whom Lord Keith agreed) and Lord Templeman somewhere between. Lord Diplock was concerned that the law relating to negligently caused injury should not be carved up across different aspects of patient care:

This general duty [of care owed by a doctor] is not subject to dissection into a number of component parts to which different criteria of what satisfy the duty of care apply, such as diagnosis, treatment and advice... [S]uch dissection... is neither legally meaningful nor medically practicable.⁸

The majority judgments have been interpreted⁹ to require that a patient was entitled to receive only the amount of information that a responsible body of medical opinion

5. *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583, 121 (McNair J). Subsequently approved in *Whitehouse v. Jordan* [1981] 1 WLR 246, *Maynard v. West Midlands RHA* [1984] 1 WLR 634.

6. *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871. See M. Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law', *Legal Studies* 7 (1987), p. 168; M. Jones, 'Informed Consent and Other Fairy Stories', *Medical Law Review* 7(2) (1999), p. 103.

7. See *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [57].

8. *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 893.

9. At least initially, Lords Kerr and Reed present a more analogical account in *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11. See criticism in C. Hobson, 'No (,) More Bolam Please: *Montgomery v Lanarkshire Health Board*', *Modern Law Review* 79(3) (2016), p. 488.

considered relevant. The implication was that disclosure of information (or, as Lord Diplock termed, ‘advice’) was considered an aspect of treatment and diagnosis, and thus a matter of clinical judgment. We will see in the next section that this did not prove workable because it did not allow the law to protect patients from medical paternalism. Nonetheless, we will later argue that Lord Diplock’s warning about the practical difficulties in dissecting the duty of care was prescient.

In relation to both treatment/diagnosis and information disclosure, *Bolam* enhanced certainty by giving HCPs confidence that differing perspectives would not necessarily be viewed in law as evidence of substandard care. From a patient perspective, however, *Bolam* made it difficult to establish breach and set a tone of deference to the medical profession that applied in both court and practice. In cases where different and discordant expert medical opinions existed, the HCP merely had to conform to one of them.¹⁰ *Bolam* also offered a judicial solution to wider matters of medical ethics and complex clinical questions. Swoboda has described ‘The deep ossification of the *Bolam* test in the common law’.¹¹ Brazier and Miola refer to a process of ‘Bolamisation’¹² whereby the courts abrogated responsibility for ethical issues and lacunae in the law into the hands of doctors. What ought to be done became, by default, what reasonable doctors would ordinarily do.¹³ In particular, *Bolam* dominated the test by which a patient’s best interests was determined. This was particularly apparent in cases on sterilisation of patients lacking capacity¹⁴ and the withdrawal of life-sustaining treatment.¹⁵ Brazier and Miola also present evidence of a subtler infiltration in *Gillick v. West Norfolk and Wisbech Area Health Authority*,¹⁶ which set out the test for child competence, and subsequent cases concerning treatment refusal, where they argue that covert application of *Bolam* effectively determined the reasonableness of treatment in the child’s best interests.¹⁷

The extension of *Bolam* was influenced by the sociocultural context. Decided in 1957, the National Health Service was in its infancy. Social factors such as class differences between most doctors and their patients and costly NHS reforms that limited the

10. *Maynard v. West Midlands RHA* [1984] 1 WLR 634.

11. J.-P. Swoboda, ‘Bolam: Going, Going, Gone’, *Journal of Personal Injury Law* 9(1) (2018), p. 14.

12. M. Brazier and J. Miola, ‘Bye Bye Bolam: A Medical Litigation Revolution?’, *Medical Law Review* 8(1) (2000), p. 85; and see M. Brazier and J. Montgomery, ‘Whence and Whither “Modern Medical Law”’, *Northern Ireland Legal Quarterly* 70(1) (2019), p. 5, at 20.

13. See M. Davies, ‘The “New Bolam”: Another False Dawn for Medical Negligence?’, *Professional Negligence* 12 (1996), p. 10: ‘[w]hen in doubt “Bolamise”’.

14. *Re F (Mental patient sterilisation)* [1990] 2 AC 1. See Brazier and Miola, ‘Bye Bye Bolam’, p. 92.

15. *Airedale NHS Trust v. Bland* [1993] 1 All ER 821 (HL); *Re G* [1995] 2 FLR 528. Brazier and Miola, op. cit., pp. 92–93.

16. [1985] 3 All ER 402 (HL). C/f J. Montgomery ‘Children as Property?’ *The Modern Law Review* 51 (1988), p. 323.

17. *Re R (A Minor) (Wardship Medical Treatment)* [1991] 4 All ER 177 (CA); *Re W (A Minor) (Wardship: Medical Treatment)* [1992] 4 All ER 627 (CA). Brazier and Miola, ‘Bye Bye Bolam’, p. 94.

potential for patient choice provided the backdrop to the decision.¹⁸ Evidence of clinical efficacy was sparse or anecdotal in contrast to the era of evidence-based medicine in which we now reside. Doctors set themselves apart in their expertise, and the courts relied on them in complex and uncertain clinical and ethical cases.¹⁹ Medical regulation was scant and there was little by way of detailed guidance from regulatory bodies. These factors resulted in greater reliance on clinical judgment and information disclosure was dominated by the principle of doing no harm.²⁰

The *Bolam* betrayal

The context has since changed dramatically. The National Institute for Clinical Excellence (now the National Institute for Health and Care Excellence (NICE)) was established in 1999 and evidence-based medicine has become the norm.²¹ Guidance from Royal Colleges and regulatory bodies is increasingly detailed and prolific. Where interaction was once dominated by a doctor–patient relationship, decisions are increasingly made between the patient and a team of HCPs.²² Change was also driven by developments in human rights,²³ an information revolution and the rise of consumerism.²⁴ The social and legal changes have been heralded as moving from patient as ‘passive recipient’ to patient as active participant²⁵: from doctor- to patient-centred practice.

Devaney and Holm argue that paternalism and deference once went hand in hand, but legal and policy initiatives²⁶ emphasising patient choice, have been successful in limiting paternalism.²⁷ These sociocultural transformations impacted on *Bolam*’s dominance across different applications. We will focus on the changes with regard to disclosure of

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18. R. Schwartz and A. Grubb, ‘Why Britain Can’t Afford Patient Choice’, *Hastings Center Report* 15(4) (1985), p. 19, at 22.
 19. S. Devaney and S. Holm, ‘The Transmutation of Deference in Medicine: A Medico-Legal Perspective’, *Medical Law Review* 26(2) (2018), p. 202, at 206.
 20. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [74].
 21. T. Hope, *Evidence-Based Patient Choice* (London: The King’s Fund, 1997).
 22. See *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [75]–[76] and S. Holm, ‘Final Responsibility for Treatment Choice: The Proper Role of Medical Doctors?’, *Health Expectations* 14(2) (2011), p. 201.
 23. See T.T. Arvind and A. McMahon, ‘Responsiveness and the Role of Rights in Medical Law: Lessons From Montgomery’, *Medical Law Review* (2020), forthcoming. Available at: <https://doi-org.ezphost.dur.ac.uk/10.1093/medlaw/fwaa006>.
 24. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [75]–[81]. The focus on consumerism is discussed critically below.
 25. Op. cit., [75].
 26. For example: DHSC, *Choosing Health: Making Choices Easier* (London, 2004); DHSC, *Choice Matters: Putting Patients in Control* (London, 2007); DHSC, *Operational Guidance to the NHS: Extending Patient Choice of Provider* (London, 2011); DHSC, *Liberating the NHS: No Decision About Me, Without Me* (London, 2012); NHS, *Five Year Forward View* (London, 2014).
 27. Devaney and Holm, ‘The Transmutation of Deference’. And see O. Quick, *Regulating Patient Safety: The End of Professional Dominance* (Cambridge: CUP, 2017), p. 24.

information and advice, but it is worth briefly noting constraints on the *Bolam* test in relation to treatment and diagnosis cases and beyond.

Bolam continues to apply to medical treatment and diagnosis cases,²⁸ but the House of Lords made efforts to correct what they saw as a misinterpretation of *Bolam* in *Bolitho v. City and Hackney Health Authority*.²⁹ This 1997 decision enhanced the potential for judges to question the logic of medical judgments. Lord Browne-Wilkinson added a gloss to the *Bolam* test, recognising that ‘if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible’.³⁰ The *Bolitho* judgment reasserted boundaries: judges must scrutinise the foundation of medical opinion and must be satisfied that it rests on logical foundations, but it only goes so far. The *Bolitho* gloss will only apply where ‘a judge can be satisfied that the body of expert opinion cannot be logically supported at all’.³¹

While *Bolam* applies in cases of misdiagnosis that result in harmful treatment,³² it has less relevance to *pure* misdiagnosis cases, where a diagnosis is either right or wrong and does not result in the balancing of risks and benefits in order to determine whether to treat. In *Muller v. King’s College Hospital NHS FT*,³³ Mr Muller was misdiagnosed by a histopathologist. He was told a malignant melanoma was in fact an ulcer which delayed effective treatment. One expert argued that a reasonable competent histopathologist could have made such an error. On a straightforward application of *Bolam*, there would be no finding of negligence. However, Kerr J was unconvinced of *Bolam*’s fit:

In a case involving advice, treatment or both, opposed expert opinions may in a sense both be “right”, in that each represents a respectable body of professional opinion. The same is not true of a pure diagnosis case such as the present, where there is no weighing of risks and benefits, only misreporting which may or may not be negligent.³⁴

28. See, for example, *Dyson v. Heart of England NHS Foundation Trust* [2017] EWHC 1910 (QB).

29. *Bolitho v. City and Hackney Health Authority* [1998] AC 232.

30. Op. cit., 243 (Lord Browne-Wilkinson).

31. Op. cit.

32. *Maynard v. West Midlands RHA* [1984] 1 WLR 634. And see discussion of *Taylor v. Dailly Health Centre* [2018] CSOH 91, below.

33. *Muller v. King’s College Hospital NHS FT* [2017] EWHC 12 (QB). See also *Lillywhite v. UCL Hospitals NHS Trust* [2005] EWCA Civ 1466 and *XXX v. King’s College Hospital NHS FT* [2018] EWHC 646 QB, discussed in S. Fox QC, *Bolam is Dead, Long Live Bolam!* (2 October 2018). Exchange Chambers blog post. Available at: <https://www.exchangechambers.co.uk/bolam-is-dead-long-live-bolam-simon-fox-qc/> (accessed 30 March 2020).

34. *Muller*, op. cit., [75]. And see *Penney v. East Kent HA* [2000] PNLR 323, 334 (HHJ Peppitt QC).

Bound by the law, Kerr J found that negligence was established, not by dis-applying *Bolam* to purely diagnostic errors but by applying the *Bolitho* gloss.³⁵ Poole has argued that this point is likely to be developed should a case on pure misdiagnosis or misreporting reach the higher courts.³⁶

The Bolamisation process referred to by Brazier and Miola has also been restricted. In the context of mental capacity, best interests had been equated with acting in accordance with an accepted body of medical opinion in *Re F*,³⁷ but this notion was criticised in *Re S*.³⁸ There, Butler-Sloss P acknowledged that the starting point in a medical decision is *Bolam*, but there may be more than one *Bolam*-compliant option and the court's role is to determine the best option.³⁹ Section 4 of the Mental Capacity Act 2005 now takes a patient-centred approach, evaluating the 'best' option in light of the patient's values.⁴⁰

What of non-disclosure of information? In *Bolitho*, Lord Browne-Wilkinson's observations focused on treatment and diagnosis cases.⁴¹ Two separate qualifications in relation to information disclosure were set out in *Sidaway*. They were, however, of limited value to patients. First, the judgment distinguished cases where questions were raised directly by the patient, in which case a duty would arise.⁴² This was problematic, not least because the patient may lack the clinical expertise to know to raise the question.⁴³ A second qualification related to disclosures that are 'so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it', for example 'if there was a substantial risk of grave adverse consequences, as, for example, the ten per cent risk of a stroke'.⁴⁴ This qualification was described by Lords Kerr and Reed in *Montgomery* as 'inherently instable': the application of the *Bolam* test to information disclosure emphasised the relevance of clinical judgment which sat uneasily with the recognition that patients are entitled to make an informed choice.⁴⁵ The Supreme Court recognised that, as a result, the qualification has been restrictively applied.⁴⁶

35. [1997] 3 WLR 1151; [1998] AC 232. See also *Brady v. Southend University Hospital NHS FT* [2020] EWHC 158 (QB), 23 (Andrew Lewis QC).

36. N. Poole QC, 'Learned Friend: Bolam Under the Microscope' (6 February 2017). Available at: <https://nigelpooleqc.blogspot.com/2017/02/bolam-under-microscope.html> (accessed 30 March 2020).

37. *Re F (Mental patient sterilisation)* [1990] 2 AC 1.

38. *Re S (Adult Patient: Sterilisation)* [2001] Fam 15.

39. See *Aintree University Hospital NHS Foundation Trust v. James* [2013] UKSC 67, [24] (Lady Hale).

40. Op. cit.: 'The advantage of a best interests test was that it focused upon the patient as an individual, rather than the conduct of the doctor'.

41. *Bolitho v. City and Hackney Health Authority* [1998] AC 232, 243 (Lord Browne-Wilkinson).

42. *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 902–903 (Lord Templeman).

43. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [58]–[59].

44. *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 900 (Lord Bridge).

45. See *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [61].

46. Op. cit.

In *Sidaway*, information disclosure was judged by the majority to constitute an integral part of medical treatment. Lord Scarman, dissenting, stated: ‘The profession, it is said, should not be judge in its own cause’.⁴⁷ He pointed out the existence of ‘the patient’s right to make his own decision’ or ‘self-determination’,⁴⁸ which is protected by the common law and ought not depend merely on medical considerations. Lord Scarman supported a test for materiality that put the patient centre-stage. HCPs would be required to disclose risks to which a reasonable patient would attach significance.⁴⁹ As we have seen, Lord Diplock’s position was that doctors are better equipped to determine reasonableness than the courts, but the single test proved problematic in relation to information disclosure, because judgment as to its adequacy is less dependent on medical expertise.⁵⁰

So began a disaggregation of treatment/diagnosis and information non-disclosure.⁵¹ The courts effected an evolution which others have charted in detail⁵² and we summarise only briefly. In *Pearce*, Lord Woolf proposed a variation on the standard of disclosure set out in *Sidaway*: ‘if there is significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk’.⁵³ Subsequently, in *Chester v. Afshar*⁵⁴ – a case on causation rather than breach – Lord Steyn asserted that: ‘[The patient’s] right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles’.⁵⁵

The steps towards a patient-centred approach to information disclosure culminated in the Supreme Court decision of *Montgomery v. Lanarkshire HB*, which rejected the test set out in *Bolam* and perpetuated in *Sidaway* (though we will argue that the extent of that

47. *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 882.

48. Op. cit.

49. Op. cit.: ‘The courts should not allow medical opinion as to what is best for the patient to override the patient’s right to decide for himself whether he will submit to the treatment offered him’.

50. I. Kennedy, ‘The Patient on the Clapham Omnibus’, *The Modern Law Review* 47 (1984), p. 454.

51. In the UK and internationally: And in USA: *Canterbury v. Spence* (464 F2d 772, 782 DC Cir 1972); Canada: *Reibl v. Hughes* [1980] 2 SCR 880; Australia: *Rogers v. Whitaker* (1992) 175 CLR 479; Malaysia: *Foo Fio Na v. Dr Soo Fook Mun* (2007) 1 *Malayan Law Journal* 593; Singapore: *Hii Chii Kok v. (1) Ooi Peng Jin London Lucien; (2) National Cancer Centre* [2017] SGCA 38, (Hii).

52. A. MacLean, ‘The Doctrine of Informed Consent: Does It Exist and Has It Crossed the Atlantic?’ *Legal Studies* 24 (2004), p. 386; A.-M. Farrell and M. Brazier, ‘Not so New Directions in the Law of Consent? Examining *Montgomery v Lanarkshire Health Board*’, *Journal of Medical Ethics* 42(2) (2015), p. 85.

53. *Pearce v. United Bristol Healthcare NHS Trust* [1999] PIQR 53, 21. And see *Marriott v. West Midlands HA* [1999] 1 Lloyd’s Rep Med 23; *Wyatt v. Curtis* [2003] EWCA Civ 1779; *Birch v. University College London Hospital NHS FT* [2008] EWHC 2237 (QB).

54. *Chester v. Afshar* [2004] UKHL 41.

55. Op. cit., [24] and see [18]. See G. Turton, ‘Informed Consent to Medical Treatment Post-*Montgomery*: Causation and Coincidence’, *Medical Law Reports* 27(1) (2019), p. 108.

rejection is unclear) in favour of a patient-centred test.⁵⁶ The decision recognised the right of persons to determine what shall be done with their bodies. *Montgomery* effected the dissection of negligence that Lord Diplock (above) warned against: the tests in relation to treatment/diagnosis and information disclosure were segregated. *Bolam* remains pertinent where different ‘schools of thought in medical science’ may apply, but Lords Kerr and Reed found that its application in relation to discussions of risk could lead to acceptance of ‘divergent attitudes among doctors as to the degree of respect owed to their patients’.⁵⁷ The new test of materiality in information disclosure set out in *Montgomery* is whether:

a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.⁵⁸

Communication of risk, benefit and reasonable alternatives is now judged according to what the reasonable and sometimes the actual patient wants to know.⁵⁹ *Montgomery* adopts a mixture of subjective and objective assessments. In determining materiality, the Supreme Court emphasised that it cannot be defined as a matter of statistical analysis but is specific to the facts and the characteristics of the patient.⁶⁰ The Supreme Court Justices did not make clear precisely how to determine the subjective element, but Lords Kerr and Reed did provide guidance as to the dialogue necessary to establish relevant patient characteristics.⁶¹

Practical guidance to doctors enhances the patient-centred approach taken in *Montgomery*. Pre-*Montgomery* guidance from the General Medical Council (GMC) on consent requires that patients ‘must’ be given the information ‘they want or need’ in relation to a range of issues⁶² and that doctors ‘should’ ‘explore these matters with patients, listen to their concerns, ask for and respect their views, and encourage them to ask questions’. Post-*Montgomery*, new draft GMC guidance replaces ‘should’ with ‘must’.⁶³ In addition,

56. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11. For details of the facts, *ratio decidendi* and subsequent development, see S. Devaney, C. Purshouse, et al., ‘The Far-Reaching Implications of *Montgomery* for Risk Disclosure in Practice’, *Journal of Patient Safety and Risk Management* 24(1) (2018), p. 25.

57. *Montgomery*, op. cit., [84].

58. Op. cit., [87]–[88]. In *A v. East Kent Hospitals NHS FT* [2015] EWHC 1038 ‘theoretical, negligible or background’ risks did not need to be disclosed.

59. *Montgomery*, op. cit., [55], [87].

60. Op. cit., [89].

61. Op. cit., [90]; and see *Thefaut v. Johnson* [2017] EWHC 497 (QB), [58]–[59] (Green J).

62. GMC, *Consent: Patients and Doctors Making Decisions Together* (2008), para. 9. Available at: https://www.gmc-uk.org/static/documents/content/Consent_-_English_0617.pdf (accessed 30 March 2020). The GMC appeared as interveners in the *Montgomery* case.

63. GMC, *Draft Guidance for Consultation: Decision Making and Consent: Supporting Patient Choices About Health and Care* (2018), para. 11. Available at: <https://www.gmc-uk.org/about/get-involved/consultations/review-of-our-consent-guidance> (accessed 30 March 2020).

it requires doctors to tailor information to patient needs, wishes, values and priorities as well as their level of understanding and the nature of the proposed options.⁶⁴ While *Montgomery* endorsed a view already adopted by the GMC, the Council's draft revised guidance is testament to the practical importance of the legal development and the need to operationalise the *Montgomery* principles beyond the law of negligence.

The *Bolam* retribution

One of the themes that has been taken forward in case law post-*Montgomery* is that 'the *Bolam* approach is no longer appropriate in cases of informed consent'.⁶⁵ However, this section specifies ways in which the *Bolam* legacy endures. We acknowledge the need to dissect the law of negligence in *Montgomery*, so as to recognise different duties with respect to treatment/diagnosis and information disclosure. A failure to do so would have perpetuated medical dominance and paternalism. However, we also recognise the force in Lord Diplock's warning in *Sidaway* that the dissection would lead to problems of impracticability. We argue that there is a lack of clarity as to the dissection in *Montgomery* and its subsequent common law development that muddies the boundaries of *Bolam*'s continued relevance.

The effect of *Montgomery* was to overrule *Sidaway* and disapply *Bolam* with respect to information non-disclosure. Lady Hale concluded that 'once the argument departs from purely medical considerations and involves value judgments of this sort', *Bolam* 'becomes quite inapposite'.⁶⁶ This section identifies areas in which there is debate as to whether value judgments based on the needs and preferences of the patient are relevant to aspects of information non-disclosure. Where medical expertise is relevant and value judgments of the sort envisaged in *Montgomery* are not pertinent to the issue, there is an argument that *Bolam* remains relevant. *Montgomery* leaves open the possibility that the new test for materiality might apply to the reasonableness of knowledge of risk, selection of treatment alternatives, the operation of the therapeutic exception and potentially disclosure of differential diagnosis. But an alternative and dominant view reasserts the relevance of the *Bolam* test alongside the *Montgomery* test, drawing on Lords Kerr and Reed's

fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.⁶⁷

First, there was initial uncertainty as to *Montgomery*'s effect on the relevance of the *Bolam* test in cases concerning non-disclosure of information. In *Spencer v. Hillingdon*,

64. Op. cit., para. 13.

65. *Ollosson v. Lee* [2019] EWHC 784 (QB), [11] (Stewart J), paraphrasing *Webster v. Burton Hospitals NHS FT* [2017] EWCA Civ 62, [26]–[31] (Simon LJ).

66. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [115].

67. Op. cit., [82].

HHJ Collender QC applied the *Bolam* test in the context of advice on post-operative risk, subject to a *Montgomery* ‘gloss’. The test applied was: ‘would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it?’.⁶⁸ This interpretation was later rejected in *Thefaut v. Johnson*, where Green J did not accept that the *Montgomery* test is a variant of *Bolam*.⁶⁹

Second, *Bolam* has potential application in relation to the therapeutic exception, which in exceptional circumstances HCPs might employ if they consider disclosure of material information to be detrimental to the health of the patient.⁷⁰ Because of the relevance of medical expertise to its application, *Bolam* is likely to apply.⁷¹ *Montgomery* was influential in the recent Singapore Court of Appeal in *Hii Chii Kok v. Ooi Peng Jin London Lucien (Hii)*.⁷² In that case, *Bolam* was held to be relevant to the consideration of reasonable justifications for withholding information, such as waiver, emergency treatment and the therapeutic exception. We comment no further in light of arguments previously articulated by one of us that the therapeutic exception is of dubious relevance and seems unlikely to be developed or relied upon in legal proceedings.⁷³

Third, the question arises as to the test to be applied in relation to the risks associated with treatment. HCPs cannot inform patients of risks they know nothing about, but in some cases, they might be found to have constructive knowledge of risk: if information on risk is material, but the HCP did not know of it, then the question is raised as to the reasonableness of the HCP’s position. Ought this matter to be governed by *Bolam*? Austin notes that the Singapore Court of Appeal in *Hii* applied *Bolam* on the basis that the lack of information would lead to a wrongful diagnosis or negligent treatment.⁷⁴ Austin is critical of this conclusion on the basis that the crux of the action is advice on risk. The matter came before the Court of Appeal in *Duce v. Worcester Acute Hospitals NHS Trust* where a patient underwent surgery to relieve pre-existing pain and was not warned that the operation could result in serious and permanent pain. *Montgomery* was framed as a two-part test:

68. *Spencer v. Hillingdon Hospital NHS Trust* [2015] EWHC 1058, [68].

69. *Thefaut v. Johnston* [2017] EWHC 497 (QB), [62].

70. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [85], [91].

71. Hobson, ‘No (,) more Bolam please’; R. Mulheron, ‘Has Montgomery Administered the Last Rites to Therapeutic Privilege? A Diagnosis and a Prognosis’, *Current Legal Problems* 70(1) (2017), p. 149.

72. *Hii Chii Kok v. (1) Ooi Peng Jin London Lucien; (2) National Cancer Centre* [2017] SGCA 38. See LV Austin, ‘Hii Chii Kok v (1) Ooi Peng Jin London Lucien; (2) National Cancer Centre: Modifying Montgomery’, *Medical Law Review* 27(2) (2019), p. 339.

73. E. Cave, ‘The Ill-Informed: Consent to Medical Treatment and the Therapeutic Exception’, *Common Law World Review* 46(2), (2017) p. 140. Note that it was not applicable in *Gallardo v. Imperial College Healthcare NHS Trust* [2017] EWHC 3147 (QB) discussed below.

74. *Hii Chii Kok v. (1) Ooi Peng Jin London Lucien; (2) National Cancer Centre* [2017] SGCA 38, [133], [147]; Austin, ‘Hii Chii Kok’.

(1) What risks associated with an operation were or should have been known to the medical professional in question. That is a matter falling within the expertise of medical professionals [83].

(2) Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine [83]. This issue is not therefore the subject of the *Bolam* test and not something that can be determined by reference to expert evidence alone [84]–[85].⁷⁵

The two parts are distinguished on the basis of the relevance of expertise to the judgment of reasonableness: *Bolam* governs the matter of whether the risks were or should have been known; if so, *Montgomery* governs the question of whether the patient should have been informed. In *Duce*, the second part of the test (materiality) was irrelevant in light of the fact that the first part was not satisfied: the risks were not considered by medical experts to be known risks at the relevant time. From a patient's perspective, the dual operation of *Bolam* and *Montgomery* and reliance on expert opinion in determining constructive knowledge of risk might seem to perpetuate the HCP-centred standard set out in *Bolam*. They might argue that their values are potentially relevant to the matter of what risks should have been known.

Fourth, a duty to warn of reasonable alternatives that carry fewer or no risks was upheld in *Birch v. University College London Hospital NHS Foundation Trust*,⁷⁶ and a requirement to discuss 'any reasonable alternative or variant treatments' was recognised in *Montgomery*.⁷⁷ In *Montgomery*, the non-disclosure of risk relating to shoulder dystocia was directly related to the requirement to inform the patient of alternative treatment by caesarean.⁷⁸ This may be the extent of the duty to discuss alternatives, in which case *Bolam* remains pertinent to the reasonableness of clinicians' decisions regarding treatment selection, except where selection is necessitated by the communication of a material risk. If a failure to consider an alternative does not breach *Bolam*, then it is less likely to be considered a 'reasonable' alternative, even if it would not breach *Bolam* for a clinician to offer that alternative. Poole warns that this has potential to undermine *Montgomery*:

75. [2018] EWCA Civ 1307, [33] (paragraphs in bracket refer to *Montgomery*): see discussion in N. Poole QC, Learned Friend Blog: 'After Montgomery: Part One: Bolam Returns' (11 September 2018). Available at: <https://nigelpooleqc.blogspot.com/2018/09/after-montgomery-part-one-bolam-returns.html> (accessed 30 March 2020). Applied in *Kennedy v. Frankel* [2019] EWHC 106 (QB), [12] (Yip J).

76. *Birch v. University College London Hospital NHS FT* [2008] EWHC 2237 (QB), on which see Rob Heywood, 2009. See also *R (Burke) v. General Medical Council (Official Solicitor and Others Intervening)* [2005] EWCA 1003, [51].

77. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [87].

78. See M. Dunn, K.M.W. Fulford, J. Herring, et al., 'Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Treatment', *Health Care Analysis* 27(2) (2019), p. 110.

Suppose there is an innovative treatment being used by 10 per cent of clinicians in a particular field, and that the patient's clinician knows about it but considers it not to be a reasonable alternative because it has not been sufficiently tried and tested. If the *Bolam* test applies then the Court might well find that it was not negligent to have failed to have mentioned the alternative to the patient. Is that not the very paternalism that the Supreme Court in *Montgomery* was striving to end?⁷⁹

An argument might be advanced that *Montgomery* has wider relevance to treatment alternatives: if a reasonable patient would find the alternative significant or the clinician is aware that the particular patient would find it so, then it ought to be put to the patient.⁸⁰ On this basis, alternatives should sometimes be communicated to the patient, even if they would pose greater clinical risk than the clinically optimal treatment, because it would be for the patient to choose between them according to their values and preferences. *Bolam* would still be relevant to the *selection* of treatment alternatives insofar as the clinician should offer alternatives unless no reasonable doctor would do so. This would maximise the patient's opportunity to decide whether a clinically riskier treatment is in fact better suited to their values and preferences.

However, there has been a marked judicial reluctance to adopt such an approach. We focus in this section on the doctrinal development to demonstrate the continued relevance of *Bolam* in aspects of the HCP's advisory role. In the next section, we turn to the rationale behind it. In *Bayley v. George Eliot Hospital*, the claimant argued that she ought to have been advised of an alternative treatment that she would have been willing to fund privately.⁸¹ HHJ Worster rejected this argument. The alternative was a possible option, but in 2008 it was not an *appropriate* option.⁸² Elements of *Bolam* flow from the judge's focus on the reasonable competent surgeon in 2008.⁸³

In Scotland in 2018, Lord Boyd issued an Opinion arising from the use of vaginal mesh products in the treatment of the pursuers in which the definition of reasonable treatment options was contested. Lord Boyd found that *Montgomery's* application was restricted to communication of the *risks* associated with treatment options.⁸⁴ The *Hunter v. Hanley*⁸⁵ test (broadly the Scottish equivalent of *Bolam*) was relevant to decisions about diagnosis and treatment. A different approach was taken in *Hii* (Singapore) where the court articulated certain alternatives HCPs are not bound to disclose including 'fringe' treatments, alternative medicine, or 'mainstream treatment options which are

79. Poole, 'After Montgomery'. See also N. Poole QC, *Clinical Negligence Made Clear* (Bath: Bath Publishing, 2019), p. 118.

80. See, for example, L. Sutherland QC, 'Montgomery: Myths, Misconceptions and Misunderstanding', *Journal of Personal Injury Law* 3 (2019), p. 157.

81. [2017] EWHC 3398.

82. Op. cit., [99].

83. Poole, 'After Montgomery'. And see *Kennedy v. Frankel* [2019] EWHC 106 (QB), [12]–[13] (Yip J).

84. *Opinion of Lord Boyd of Duncansby in the cause AH v. Greater Glasgow Health Board* [2018] CSOH 57, [38]–[45].

85. [1955] SLT 213, [1955] ScotCS CSIH.

obviously inappropriate on the facts',⁸⁶ the assessment of which comes under *Bolam*.⁸⁷

In England and Wales, it seems that a narrow approach to *Montgomery*'s application to reasonable alternatives is emerging, particularly where treatment is urgently required. A failure to identify an alternative is most likely to amount to breach of the duty if it is relevant to the risk of proposed treatment.⁸⁸ However, a wider approach may yet be consolidated in relation to elective procedures where, for example, dialogue around more conservative alternatives may be key,⁸⁹ or in novel procedures, where dialogue around standard options is important.⁹⁰

A related issue arises around the duty to inform patients of alternative treatments where diagnosis is uncertain ('differential diagnosis'). 2008 GMC guidance requires that patients are given information about diagnosis and prognosis and uncertainties thereof.⁹¹ Pre-*Montgomery*, in *Meiklejohn v. St George's Healthcare NHS Trust*, it was said that the duty to warn of alternative diagnoses comes under *Bolam* and *Sidaway*.⁹² Post-*Montgomery* it might be argued that dialogue around differential diagnosis is required where it affects the range of alternatives and their relative risks and benefits. However, in light of *Duce* and the restrictive approach taken to date around treatment alternatives, if the differential diagnosis does not breach the duty of care according to *Bolam*, *Montgomery*'s relevance as to its communication to the patient seems likely to be limited.

In the Scottish case of *Taylor v. Dailly Health Centre*,⁹³ 32-year-old Mrs Taylor suffered chest pain and subsequently died after a General Practitioner (GP) misdiagnosed her with gastro-intestinal upset and musculoskeletal pain. One of the claims was that the GP had not obtained her informed consent because she was not advised of the risk of alternative diagnosis – acute coronary syndrome – and accompanying treatment options. Finding that *Montgomery* was irrelevant, Lord Tyre said:

A distinction fell to be drawn between (i) the doctor's role when considering possible investigatory or treatment options, and (ii) the doctor's role in discussing with the patient any recommended treatment and possible alternatives. The first remained an exercise of

86. *Hii Chii Kok v. (1) Ooi Peng Jin London Lucien; (2) National Cancer Centre* [2017] SGCA 38, [142].

87. Austin, 'Hii Chii Kok', 9.

88. For example, *Tasmin v. Barts Health NHS Trust* [2015] EWHC 3135 (QB) where 'A risk of 1:1,000 is an immaterial risk for the purposes of paragraph 87 of *Montgomery*' [118] (Jay J). Therefore, there was no requirement to inform the patient of a particular alternative.

89. *Thefaut v. Johnston* [2017] EWHC 497 (QB); *Hassell v. Hillingdon* [2018] EWHC 164 (QB) c/f *Morocz v. Marshman* [2015] NSWSC 325 (New South Wales: argument that patient should have been warned not to undertake the cosmetic procedure she had extensively researched).

90. *Mills v. Oxford University Hospitals NHS Foundation Trust* [2019] EWHC 936 (QB).

91. GMC, *Consent*, para. 9 and see paras 2, 18, 37.

92. [2014] EWCA Civ 120, [62] (Rafferty LJ).

93. *Taylor v. Dailly Health Centre* [2018] CSOH 91.

professional judgment, and [in this case] no duty existed to discuss that judgment with the patient or seek consent to treat the patient in accordance with it.⁹⁴

In 2020, the Paterson Inquiry recommended strengthened procedures to ensure that patients are properly informed of their *diagnosis* as well as their treatment options.⁹⁵ Should a case in England and Wales arise, this might influence judges to extend the remit of *Montgomery* to require communication of differential diagnosis, at least where it raises the possibility of less risky treatment.

It is possible to discern three explanations in *Montgomery* for the respective relevance of *Bolam* and *Montgomery* tests: The distinction between selection of treatment options versus the discussion of those options with the patient focuses on the difference between treatment/diagnosis and informed consent; the relevance of different schools of medical thought versus different approaches to respect for patient choice focuses on the role of medical expertise; and the relevance of the patient's values to the decision focuses on the protection of patient rights. The explanations are generally harmonious but may conflict. For example, the division in *Montgomery* between the role of HCPs in selecting treatment options, making diagnoses and understanding the risks, and their role in disclosing material information to patients so as to allow them to make an autonomous choice is problematic insofar as the GMC acknowledges that patient values can be relevant to selection of treatment options.⁹⁶ There may be cases where patient values render *Bolam* 'inapposite', notwithstanding the relevance of medical expert evidence to determine reasonableness. Subtle differences in rationale may also have resulted in latitude in the subsequent application of *Montgomery*, resulting in a degree of 'Bolam creep'.

In conclusion of this section, we have argued that Lord Diplock's warning about the practicability of dissecting the law of negligence has some bearing. Whilst there is force in the argument that his view flowed principally from conservatism and deference to the medical profession,⁹⁷ we would argue that it is also based on the practical difficulties in some cases of distinguishing advice and treatment/diagnosis. *Bolam*'s 'legacy' flows from the unclear division, which raises questions as to the extent to which *Bolam* remains relevant to the assessment of reasonableness of aspects of medical advice. We have argued that the resolution of this debate is far from settled.

The *Montgomery* enigma

We move now from the continuing doctrinal relevance of *Bolam* in cases of non-disclosure of risk, reasonable alternatives and differential diagnosis, to its wider

94. Op. cit., [40].

95. DHSC, *Report of the Independent Inquiry into the Issues Raised by Paterson*. 2020 HC 31, pp. 218–219.

96. GMC, *Consent*, para. 9. GMC guidance is not law, but the guidance was favourably considered in *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [69], [77], [78], [93] (Lords Kerr and Reed), [107], [109] (Lady Hale).

97. J. Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Oxford: Hart, 2007), p. 57.

influence in relation to medical advice. Notwithstanding the metaphorical legal and cultural nails in *Bolam*'s coffin, the paternalistic ethos perpetuated in *Bolam* has proved difficult to curtail. In this section, we explore three reasons for this: that *Montgomery* seemingly endorses a consumeristic conception of patient choice, that the paternalistic ethos is deeply ingrained in practice, and that outside the confines of negligent non-disclosure of material risk, the principles endorsed in *Montgomery* are not equally relevant to all aspects of medicine.

The *Montgomery* decision was based on principles of self-determination,⁹⁸ partnership,⁹⁹ support,¹⁰⁰ choice,¹⁰¹ and a move away from paternalism¹⁰² but also on consumerism.¹⁰³ Seeming acceptance of consumerism has potential to create unrealistic expectations of patient choice and blur the divide between selection of clinically appropriate treatments and patient choice between them. In this section, we set out a normative argument for a clearer balance of patient choice and HCP expertise. Recognition that *Bolam* is relevant to the selection of reasonable treatment options is problematic if it leads to patient values being ignored. Similarly, recognition of the importance of patient choice is problematic if clinical expertise is ignored. *Montgomery* requires a revised professional autonomy rather than its abandonment.¹⁰⁴ There is a role for clinical expertise in the selection of relevant treatment options and in support of patients when they choose between them that is potentially disrupted by emphasis in *Montgomery* on consumerism. Conceptual clarification is required to recognise and better define the extent of professional autonomy.

The rise of consumerism is not new. The internal market was introduced in the NHS and Community Care Act 1990, assigning the role of purchaser to District Health Authorities and encouraging providers to reduce costs and enhance efficiency. According to the King's Fund, these early reforms had limited impact as incentives were weak, constraints strong and information insufficient.¹⁰⁵ It resulted in culture change, however, encouraging greater focus on patient needs.¹⁰⁶ New Labour retained the purchaser provider split and brought in commissioning. Market reforms were gradually introduced,

98. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [80] (Lords Reed and Kerr), [108] (Lady Hale).

99. Op. cit., [77]–[78].

100. Op. cit., [90] (Lords Reed and Kerr), [110], [116] (Lady Hale).

101. Op. cit., [75].

102. Op. cit., [81].

103. Op. cit., [75].

104. J. Laing, 'Delivering Informed Consent Post-Montgomery: Implications for Medical Practice and Professionalism', *Professional Negligence* 33 (2017), p. 128; Devaney and Holm, 'The Transmutation of Deference'; A theory as to how patient choice and professional autonomy might be balanced is set out in E. Cave, 'Selecting Treatment Options and Choosing Between them: Delineating Patient and Professional Autonomy in Shared Decision-Making', *Health Care Analysis* 28 (2020), p. 4.

105. N. Mays, A. Dixon and L. Jones, *Understanding New Labour's Market Reforms of the English NHS* (London: King's Fund, 2011), p. 3.

106. Op. cit.

starting with a new focus on patient choice to enhance the patient experience in the *NHS Plan*¹⁰⁷ and introducing greater flexibility for providers through Foundation Trust status and Payment by Results. Market-based approaches were extended in the Health and Social Care Act 2012,¹⁰⁸ underpinned by an ‘information revolution’.¹⁰⁹ Competition resulted in a mix of private and state-run NHS organisations which, Sturgeon argues, made the NHS more business-like and consumeristic.¹¹⁰ Sturgeon points out that the ‘necessity’ of consumption in the NHS makes for valuable commercial opportunities and thus drives consumerism.¹¹¹

The Supreme Court Justices reference choice 17 times in *Montgomery*. Lords Kerr and Reed recognise that patients are ‘widely treated as consumers exercising choices’.¹¹² Consumerism can have value in the pressure it brings to bear to reform practice,¹¹³ but critics point to the unsuitability of a consumer model in healthcare on the basis that patients need support rather than an individualised choice architecture.¹¹⁴ Consumerism can also lead to unmet patient expectations: it denotes a *wide range* of choice that is in practice limited. Choice is limited by resources, evidence of clinical need and beneficent obligations including Section 1 of the Health and Social Care (Safety and Quality) Act 2015¹¹⁵ which requires the Secretary of State to ensure that services cause ‘no avoidable harm’ to service users.¹¹⁶ The Care Quality Commission states ‘providers must not provide unsafe or inappropriate care just because someone has consented to care or treatment that would be unsafe’.¹¹⁷ Competition has been introduced, with varying degrees of success, to allow some choice of *provider*, though there is still considerable control by HCPs as to when to refer and to what specialism. In relation to choice of

107. NHS Plan (DH, 2000). And see *Health Reform in England: Update and Next Steps* (DH, 2005).

108. See King’s Fund, *Is the NHS Being Privatised?* (2017). Available at: <https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised> (accessed 30 March 2020).

109. White Paper, *Liberating the NHS: An Information Revolution* (DH, 2010).

110. D. Sturgeon, ‘The Business of the NHS: The Rise and Rise of Consumer Culture and Commodification in the Provision of Healthcare Services’, *Critical Social Policy* 34(3) (2014), p. 405.

111. Op. cit.

112. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [75].

113. Op. cit., [75]. And see M.K. Sheppard, ‘Fallacy or Functionality: Law and Policy of Patient Treatment Choice in the NHS’, *Health Care Analysis* 24(4) (2016), p. 279.

114. I. Greener, ‘Are the Assumptions Underlying Patient Choice Realistic? A Review of the Evidence’, *British Medical Bulletin* 83(1) (2007), p. 249, at 256; R. Downie, ‘Patients and Consumers’, *The Journal of the Royal College of Physicians of Edinburgh* 14 (2017), p. 261, at 264.

115. Amending Health and Social Care Act 2008, s. 20.

116. See D. Wilkinson and J. Savulescu, ‘Cost-equivalence and Pluralism in Publicly-Funded Health-Care Systems’, *Health Care Analysis* 26(4) (2018), p. 287.

117. CQC, *Regulation 11: Need for Consent*. Available at: <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-11-need-consent#full-regulation> (accessed 30 March 2020).

treatment, in 1985 Schwartz and Grubb claimed that Britain could not afford informed consent because the system could not respect patients' reasonably possible choices:

Ultimately, the existence of a national health system, prospectively funded by a central planning authority and with limited and defined resources, makes the acceptance of such a doctrine an impossibility.¹¹⁸

Primacy cannot be given to patient rights to decide which treatment suits them best in the way that it can in a system where consumers more directly fund their treatment.¹¹⁹ Notwithstanding creeping privatisation of the NHS, treatment in the NHS remains largely free at the point of delivery and Schwartz and Grubb's argument remains relevant. Patient choice cannot extend to the right to demand treatment, though there is evidence of increasing pressure on clinicians to comply with patient demands even when the options sought by patients are not clinically indicated.¹²⁰ Rather, patient preferences must often give way to medical criteria, including the allocation of resources. Though Lords Kerr and Reed are clear that professional expertise remains central to the selection of suitable treatment options, the emphasis on consumerism in *Montgomery* is unfortunate. In dismantling HCP-centred medicine, care must be taken to distance anti-paternalism from unmitigated patient choice. The HCP role in selecting treatment options can be carried out in a patient-centred manner that takes into consideration patient values, without compromising the professional duty to base medical treatment decisions on clinical need, evidence of efficacy and available resources.¹²¹

We have described a conflict of principles set out in *Montgomery*. Emphasis is placed on consumerism that has potential to cause opacity in relation to the selection of treatment options and the choice between them and raise patient and HCP expectations that patients can choose treatment options that HCPs do not consider clinically justifiable. But the Supreme Court also acknowledged the importance of dialogue and partnership. It is apparent that the rejection of *Bolam* in *Montgomery* does not denote a rejection of the role of HCP support in the choice between options. Nor does acceptance of the role of medical expertise in the selection of treatment options mean that consideration of patient values is excluded from the exercise. Shared decision-making is relevant to both selection and choice between options.¹²²

118. Schwartz and Grubb, 'Why Britain'.

119. Op. cit., 25. See *R (Burke) v. General Medical Council (Official Solicitor and Others Intervening)* [2005] EWCA 1003.

120. D. Epstein, 'When Evidence Says No, But Doctors Say Yes' (2017) ProPublica Blog. Available at: <https://www.propublica.org/article/when-evidence-says-no-but-doctors-say-yes>. See also Human Fertilisation and Embryology Authority et al., *The Responsible Use of Treatment Add-Ons in Fertility Services: A Consensus Statement* (2019). Available at: <https://www.hfea.gov.uk/media/2792/treatment-add-ons-consensus-statement-final.pdf> (accessed 30 March 2020).

121. See Cave, 'Selecting Treatment Options and Choosing Between Them'.

122. This is so notwithstanding the tests to establish breach in negligence may differ. See Cave, op. cit.

As *Montgomery* is incrementally developed in the courts, it is important that the relevance of shared decision-making and patient autonomy are recognised and promoted. This would help facilitate the articulation of *Bolam* and *Montgomery*'s respective application, whilst promoting workable patient-centred standards in a manner that is alive to the needs of some patients for support and to the relevance of HCP expertise in determining the suitability of treatment and in providing advice.

Another part of the *Montgomery* 'enigma' is the potential gap between legal principle and application. The GMC conducted research in 2017 reporting that awareness of the *Montgomery* decision is low and doctors fear that a lack of time in consultations can prevent a full understanding of the particular patient's needs. Doctors can find assessments of capacity difficult and are not all equipped to translate complex information in a digestible form.¹²³ If cultural change can be brought about, resources are needed for implementation. But limitations on resources impact upon the time HCPs have to engage in dialogue and the alternatives that can be offered.¹²⁴ Laing has highlighted the stresses on the partnership model that the *Montgomery* judgment advocates,¹²⁵ that result from the financial pressures on the NHS and the considerable strains under which the work force operate.¹²⁶

There is also evidence of variation in *Montgomery*'s perceived relevance between specialties. The production of specific consent guidance post-*Montgomery* from the Royal College of Obstetricians and Gynaecologists,¹²⁷ Association of Anaesthesiologists,¹²⁸ Royal College of Surgeons,¹²⁹ Royal College of Nursing¹³⁰ and British Orthopaedics Association¹³¹ reflect the fact that these are the specialisms most likely to face clinical negligence litigation. Outside these areas, there is less focus on the legal changes from the Royal Colleges, at least in terms of published guidance responding to *Montgomery*. We can surmise that there may therefore be less understanding of the new

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123. Community Research, *Doctors' Attitudes to Informed Consent and Shared Decision Making: Full Research Report for the GMC* (June 2017). Available at: https://www.gmc-uk.org/-/media/documents/Doctors_attitudes_to_consent_and_shared_decision_making_FINAL_research_report.pdf_72137875.pdf (accessed 30 March 2020).
 124. GMC 'Under-Pressure Doctors Need Time for Patients, Says GMC' (24 October 2018). Available at: <https://www.gmc-uk.org/news/news-archive/consent-consultation> (accessed 30 March 2020).
 125. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [81] (Lords Kerr and Reed).
 126. Laing, 'Delivering Informed Consent Post-Montgomery'.
 127. RCOG, *Obtaining Valid Consent: Clinical Governance Advice No. 6* (2015). Available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga6.pdf> (accessed 30 March 2020).
 128. AAGBI, *Consent for Anaesthesia* (2017). Available at: https://www.aagbi.org/sites/default/files/AAGBI_Consent_for_anaesthesia_2017_0.pdf (accessed 30 March 2020).
 129. RCS, *Consent: Supported Decision-Making* (2016). Available at: <https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/consent-good-practice-guide/> (accessed 30 March 2020).
 130. RCN, *Principles of Consent: Guidance for Nursing Staff* (2015).
 131. British Orthopaedic Association, *Guidance on Consent* (2016). Available at: <https://www.boa.ac.uk/publications/guidance-documents/#toggle-id-3> (accessed 30 March 2020).

responsibilities among HCPs in those specialties that are less likely to face clinical negligence suits.

Some patient choices bypass HCPs altogether, which self-evidently limits opportunities for partnership and support relied upon in *Montgomery*. In essence, patients may rely on advice in a situation where there is no individual HCP to challenge in a lawsuit, in which case there may be less pressure on those responsible for the advice to make it compatible with *Montgomery* principles. For example, the information revolution can leave vulnerable people exposed to harmful information as seen in social media suicide posts¹³² and depictions of Anorexia Nervosa as a positive lifestyle choice.¹³³ Access to complex healthcare information that bypasses the HCP gatekeeper can pose risks of misunderstanding, as in the case of some direct-to-consumer predictive and pre-dispositional genetic testing¹³⁴ and online pharmacies.¹³⁵ In 2010, the Nuffield Council on Bioethics concluded that the government needs to do more to ensure information is accurate and consent is informed.¹³⁶ Patients can access more information than ever before and this can steer people who do not need medical intervention away from healthcare services, help patients to frame their questions for HCPs and reassure them post-consultation.¹³⁷ On the other hand, many evidence-based articles are hidden behind a paywall and misinformation can put strain on services and exacerbate public health concerns.¹³⁸ In such cases, *Montgomery* is not directly applicable, but the principle of patient-centred care remains relevant. Adherence to that principle may necessitate pressure on the government to ensure that public information is fit for purpose.

132. A. Crawford, 'Instagram 'Helped Kill My Daughter'', *BBC News* 22 January 2019. Available at: <https://www.bbc.co.uk/news/av/uk-46966009/instagram-helped-kill-my-daughter> (accessed 30 March 2020).

133. M. Bromberg and T. Fitzgerald, 'Let's Starve Down to the Bone: Pro-Anorexia Websites and the Law', *Journal of Law and Medicine* 25 (2017), p. 124.

134. A. Muhdawi, 'Why Did I Risk My Privacy with Home DNA Testing? I Blame my Neanderthal Heritage', *The Guardian* 28 March 2018. Available at: <https://www.theguardian.com/commentisfree/2018/mar/28/what-did-i-learn-from-my-diy-dna-test-how-foolish-i-was-to-sign-my-life-away> (accessed 30 March 2020).

135. T.K. Mackey and G. Nayyar, 'Digital Danger: A Review of The Global Public Health, Patient Safety and Cybersecurity Threats Posed by Illicit Online Pharmacies', *British Medical Bulletin* 118(1) (2006), p. 110; General Pharmaceutical Council, *Guidance for Registered Pharmacies Providing Pharmacy Services at a Distance, Including on the Internet* (2019). Available at: https://www.pharmacyregulation.org/sites/default/files/document/guidance_for_registered_pharmacies_providing_pharmacy_services_at_a_distance_including_on_the_internet_april_2019.pdf (accessed 30 March 2020).

136. Nuffield Council on Bioethics, *Medical Profiling and Online Medicine: The Ethics of 'Personalised Healthcare' in a Consumer Age* (London, 2010).

137. M. McMullan, 'Patients Using the Internet to Obtain Health Information: How This Affects the Patient-Health Professional Relationship', *Patient Education and Counseling* 63 (2006), p. 24.

138. For example, A. Kata, 'A Postmodern Pandora's Box: Anti-Vaccination Misinformation on The Internet', *Vaccine* 28(7) (2010), p. 1709.

Variations in treatment type might also affect *Montgomery*'s application. For example, medical advancements allow increasingly individualised care which can decrease choice and impact on the partnership model. The drive towards personalised (or precision) medicine tailors advice, prevention, diagnosis, treatment and aftercare to the individual, usually based on genetic data, rather than the disease. For example, cancer treatment can be matched to the patient's genetic make-up and tumour growth. *Montgomery* emphasises the importance of patient values,¹³⁹ but it is not clear how values will fit into personalised medicine. Clinically indicated options might be reduced to one and the advisory function of the HCP diminished, with the result that less attention is paid to the patient's particular values and preferences. Adherence to a patient-centred approach might lead to greater focus on tailoring the choices to the person as well as their genetic profile if individual values and personalised medicine are brought into tension.

Some aspects of law are regulated by statutes enacted when *Bolam* was more dominant. Take, for example, the Abortion Act 1967.¹⁴⁰ Evidence of an HCP-centred approach¹⁴¹ flows from the medicalisation of abortion. Though during the coronavirus crisis temporary approval was given to early medical abortion at home,¹⁴² the 1967 Act takes a medicalised approach whereby two registered medical practitioners must form an opinion in good faith that the abortion fits within one of a series of defences to what would otherwise constitute a crime under sections 58–59 of the Offences Against the Person Act 1861. The Act pays little heed to the process of consent and the woman's understanding of relevant information. Fifty years after the Act came into force, Lee et al. describe a shift in professional attitude that exposes tensions in the Act flowing from better support for women's choices and the rejection by HCPs of medical hierarchies.¹⁴³ The articulation of principles of information disclosure in *Montgomery* may lead to new challenges of *Bolam*-era legislation if evidence suggests that the legislation fails to support patient-centred practice.

Brazier and Montgomery persuasively argue that *Bolam* is gradually being 'left behind'. They point to the Supreme Court decision of *Darnley* as an example.¹⁴⁴ There, it was held that inaccurate information that leads to harm is actionable in an accident and emergency department, just as it would be in other settings. They see this as evidence of 'a more orthodox approach . . . to determining the standard of care in hospitals'.¹⁴⁵ We

139. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [45], [80], [115].

140. As amended by Human Fertilisation and Embryology Act 1990, s 37.

141. S. McGuinness and M. Thomson, 'Medicine and Abortion Law: Complicating the Reforming Profession', *Medical Law Reports* 23(2) (2015), p. 177.

142. DHSC, *Temporary Approval of Home Use for Both Stages of Early Medical Abortion* (30 March 2020). Available at: <https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion-2> (accessed 30 March 2020).

143. E. Lee, S. Sheldon and J. Macvarish, 'The 1967 Abortion Act Fifty Years On: Abortion, Medical Authority and the Law Revisited', *Social Science & Medicine* 212 (2018), p. 26.

144. *Darnley v. Croydon Health Services NHS Trust* [2018] UKSC 50. Note that *Bolam* was not central to the decision because receptionists are not healthcare professionals.

145. Brazier and Montgomery, 'Whence and Whither 'Modern Medical Law'', p. 24.

agree that the adoption of patient-centred principles in *Montgomery* and related cases is having a positive effect, but caution that *Montgomery*'s potential should not be exaggerated. *Montgomery* concerned a physical intervention on a living patient. Differentials among health providers (from hospitals to care homes, surgeries to hospices, private and NHS) result in the prioritisation of different missions and values. The principles of partnership and patient autonomy endorsed in *Montgomery* have relevance in research, observational studies, use of personal data, and in issues after death such as organ or tissue transplantation. In these settings, however, competing values may apply. The plurality of values outside mainstream medicine makes for uneven application of patient-centred practice and partnership. Data-sharing encompasses public interest and commercial value of data; public health emphasises the public interest, as has become so apparent in the coronavirus pandemic ongoing at the time of writing.¹⁴⁶

It is also worth noting that *Montgomery* focuses on a restricted patient group – namely ‘adult patients of sound mind’.¹⁴⁷ Patients who lack capacity, who are subject to compulsory treatment under the Mental Health Act 1983, or who are under the age of 16 and lack the competence to consent have dubious claims for negligent non-disclosure of risk, but the principles of support, participation, partnership and patient-centred medicine are relevant here too and have potential to influence legal development outside of negligence. This matter is explored in a separate paper.¹⁴⁸

This section has not sought to offer a comprehensive assessment of *Montgomery*'s relevance across healthcare, but rather to point out the potential for variability in commitment to patient values when giving medical advice, given constraints on HCP time, resources and awareness and the differences in HCP-type, patient group and healthcare setting. *Montgomery* is not a panacea in the move away from HCP-centred practice in information provision that followed the *Bolam* decision. There are cases where patient autonomy and partnership must give way to competing values.

The *Montgomery* supremacy?

We have focussed on the *Bolam* legacy in two contexts: the first is within the law of clinical negligence and the second looks beyond negligence to the potential to mitigate an entrenched Bolamised approach and deliver a patient-centred approach to medical advice. We are some way off a ‘*Montgomery* supremacy’ in both regards.

Taking the latter first, we have identified aspects of advice, areas of medicine and patient demographics where *Montgomery*'s bearing is limited. Two 2020 independent inquiries have outlined failures with regard to informed consent and the need to

146. On which see S. Devaney, J. Miola, E. Cave, et al., ‘Healthcare Professional Standards in Pandemic Conditions: The Duty to Obtain Consent to Treatment’, *Journal of Bioethical Inquiry*, forthcoming.

147. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [50], [68], [87].

148. .E. Cave, C. Purshouse, ‘Think of the Children: Liability for Non-Disclosure of Information Post *Montgomery*’, *Medical Law Review* 28(2) (2020), p. 270,

strengthen commitment to a patient-centred approach embracing partnership and patient autonomy. The Paterson Inquiry chaired by Rev'd Graham James made recommendations to improve the consent process, including writing to patients to outline their condition and treatment and to make sure the patient's GP is also informed, and giving patients a short period of time to process information about diagnosis and treatment options before surgical procedures. Additional points were made in Baroness Julia Cumberlege's medicines and medical devices safety review.¹⁴⁹ Describing *Montgomery* as 'landmark' and 'a watershed',¹⁵⁰ the 2020 report stated:

No longer can informed patient consent be anything other than a true equality of partnership in the decision making process between patients and their treating physicians. Their care and treatment should not be a series of events that happened to them. Rather, every patient should be able to stand back, look at their patient journey and say 'I recognise my hand-writing all over those choices.'¹⁵¹

The report suggests better use of patient decision aids and access to patient testimonials as part of the informed consent process. It further recommends recording conversations where appropriate, so that patients have opportunity to reflect. Both reports advise the GMC to incorporate recommendations reflecting the spirit of *Montgomery* into guidance and to monitor compliance as part of 'Good Medical Practice'.¹⁵² If this is achieved then *Montgomery*'s relevance will be expanded further beyond the law of negligence to aspects of practice where patients have a legitimate expectation of partnership and choice. In doing so it will be important to acknowledge that choices are often limited and that partnership does not equate to a patient right to demand interventions that are not clinically justified.

With regard to claims for negligent non-disclosure of information, though *Montgomery* signalled the dissection of the duty of care and the end of *Bolam*'s reign with regard to the test for materiality of risk, we have identified ways in which *Bolam* remains pertinent. The disapplication of *Bolam* in *Montgomery* is not complete, but this does not mean that the *Bolam* legacy cannot be confined where it threatens unwarranted paternalism in place of partnership and sensitivity to patient values. The significance of advice does not end with risks inherent in treatment or even with treatment. Aspects of diagnosis/treatment and information disclosure will converge when, for example, advice is needed for diagnostic testing; or where treatment necessitates advice regarding prognosis.¹⁵³ There is potential for the incremental development of *Montgomery* to enhance respect for patient autonomy and emphasise shared

149. Baroness Cumberlege (Chair), *First Do No Harm: The report of the Independent Medicines and Medical Devices Safety Review*. 2020. Available at: https://www.immndsreview.org.uk/downloads/IMMDSReview_Web.pdf (accessed 20 July 2020).

150. Op. cit., paras 2.13 and 2.19, respectively.

151. Op. cit., para. 2.17.

152. Op. cit., para. 2.24; DHSC, *Paterson Inquiry Report*, pp. 218–219.

153. *Hii Chii Kok v. (1) Ooi Peng Jin London Lucien; (2) National Cancer Centre* [2017] SGCA 38, [91].

decision-making (or ‘partnership’ as it is referred to in *Montgomery*) beyond the confines of non-disclosure of risk, benefits and reasonable alternatives, to encompass wider aspects of the HCP’s advisory role.

One method at the courts’ disposal is to apply *Montgomery* when patient values are pertinent on the facts. As we have seen, where disclosure of risk relating to one treatment option can be linked to the reasonableness of disclosure as to an alternative option, the *Montgomery* test will be relevant: the failure to offer an alternative becomes a matter of disclosure rather than treatment selection, because of the relationship to the risk inherent in the accepted treatment. The same argument might apply to other aspects of the decision-making process. For example, a differently framed *Montgomery* case could potentially have focussed on the issue of differential diagnosis. *Montgomery* involved a misdiagnosis of fetal weight.¹⁵⁴ While the question of whether there had been a misdiagnosis would fall under *Bolam*, the same is not necessarily true of failure to communicate doubt as to diagnosis (of fetal weight) if that can be linked to the risk inherent in the proposed course of action.

Another method is to extend *Montgomery*’s application beyond treatment to encompass other aspects of medical advice. The courts have shown some willingness in this regard. Shortly after the *Montgomery* decision, in *Spencer v. Hillingdon Hospital NHS Trust*, the court found that a patient was not given adequate information as to the symptoms of post-operative deep vein thrombosis.¹⁵⁵ Subsequently, in *Gallardo v. Imperial College Healthcare NHS Trust*,¹⁵⁶ Mr Gallardo was treated in 2001 for a suspected stomach ulcer that proved to be a malignant stromal tumour, but the malignancy and risk of recurrence was not disclosed to him until 2010. Judge Peter Hughes QC held that: ‘By analogy [with *Montgomery*], it is the patient’s right to be informed of the outcome of the treatment, the prognosis, and what the follow-up care and treatment options are’.¹⁵⁷ The principles set out in *Montgomery* that supported the right to be informed, also supported the patient’s ‘right to be told’.¹⁵⁸ In *Webster v. Burton Hospitals NHS FT*,¹⁵⁹ it was agreed that a failure to undertake additional ultrasound scans during pregnancy was negligent. The High Court (sitting pre-*Montgomery*) applied *Bolam* and found that a reasonable and responsible body of obstetric opinion supported the Consultant’s actions. The Court of Appeal (post-*Montgomery*) held that this was no longer the correct approach.¹⁶⁰ Had there been a proper dialogue, Mrs Webster would have opted to have labour induced. Fox argues that application of *Montgomery* in this case demonstrates the potential for application beyond non-disclosure of information to

154. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [14].

155. *Spencer v. Hillingdon Hospital NHS Trust* [2015] EWHC 1058. See commentary above re application of *Bolam* in this case and subsequent criticism.

156. *Gallardo v. Imperial College Healthcare NHS Trust* [2017] EWHC 3147 (QB).

157. Op. cit., [70].

158. Op. cit., [75].

159. *Webster v. Burton Hospitals NHS FT* [2017] EWCA Civ 62, [41] (Simon LJ).

160. Op. cit., [34] (Simon LJ).

advice more generally,¹⁶¹ at least where the patient has not been properly informed and harm has resulted.¹⁶²

A further possibility is to accept the application of *Bolam* to certain wider issues of informed consent where the matter in question turns on medical expertise and expert evidence is required to establish its reasonableness but adapt its application to limit the HCP-centred, paternalistic focus. This could potentially be achieved through the application of the *Bolitho* gloss. It will be recalled that the House of Lords in *Bolitho* corrected a misinterpretation of *Bolam*, by requiring that judges are satisfied that medical opinion rests on logical grounds. Two recent cases provide evidence that the courts are willing to question established practice on the basis that it is illogical because it is not compliant with *Montgomery*. Both are claims for damages for the upbringing of a child. In *ARB v. IVF Hammersmith*,¹⁶³ ARB claimed in breach of contract against an IVF clinic that thawed and implanted a frozen embryo into ARB's former partner without his consent, resulting in the birth of his genetic child. Jay J found at first instance that the consent form had been forged by ARB's ex-partner. The claim failed on policy grounds, but the Court of Appeal held that the clinic was in breach of its strict obligations given the lack of genuine consent. *Montgomery* was relevant to the finding that the IVF clinic's processes for obtaining consent were illogical, unreasonable and irresponsible.¹⁶⁴ This was so notwithstanding that the process was established and common to other clinics. Subsequently, in *Mordel v. Royal Berkshire NHS Foundation Trust*,¹⁶⁵ Jay J said of the *ARB* decision:

This authority is valuable to the extent that it vouches that a system which does not entail the taking of reasonable steps to ensure that relevant consent is informed may be regarded – subject always to a host of other considerations – as irresponsible, unreasonable and unspectable even if there may exist expert evidence to support it.¹⁶⁶

161. S. Fox QC, *Bolam is Dead, Long Live Bolam!* (2 October 2018). Exchange Chambers blog post. Available at: <https://www.exchangechambers.co.uk/bolam-is-dead-long-live-bolam-simon-fox-qc/> (accessed 30 March 2020). But note wrongful life case *Khan v. MNX* [2018] EWCA Civ 2609 which distinguished advice (where the advisor is responsible for guiding the whole decision-making process) and information (where the advisor contributes information relevant to one aspect of a decision made by the individual). The HCP was liable for damage resulting from negligent mis-information but not for the overall decision of the woman to become pregnant.

162. In *Price v. Cwm Taf University Health Board* [2019] EWHC 938 (QB), though an operation was not clinically indicated and was contrary to NICE guidelines, the consent process was not flawed because the operation had potential benefit of which Mr Price was informed. On the requirement of harm: 'Although harm is the focus of much of the reasoning in [*Chester* and *Montgomery*], I note the reference to dialogue and to anticipated benefits in paragraph 90 of the speech of Lord Kerr and Lord Reed in *Montgomery*.' [26] (Birss J).

163. [2018] EWCA Civ 2803.

164. *Op. cit.*, [59] (Davies LJ).

165. *Mordel v. Royal Berkshire NHS Foundation Trust* [2019] EWHC 2591 (QB).

166. *Op. cit.*, [19].

In *Mordel*, the logicity of processes designed to establish the choices of pregnant women with regard to screening for Down's syndrome was called into question. Though *Montgomery* was not 'central to the issue' it was nonetheless found to be relevant:

to underscore that the issue of consent and the need for it to be truly informed is a question of right rather than discretion; and that the patient must be provided with sufficient information to make an informed decision.¹⁶⁷

If *Bolam* is to sit more comfortably alongside *Montgomery*, then the *Bolitho* gloss might be utilised to ensure that reasonableness is viewed through the prism of *Montgomery* principles. In *Birch*, Cranston J opined that even if the failure to warn of the existence of a less risky alternative did not deny the patient the opportunity to give informed consent, 'the failure to discuss with Mrs Birch these matters could not be described in law as reasonable, responsible or logical'.¹⁶⁸

Post-*Bolam*, judges were initially reluctant to evaluate an HCP's reasonableness and responsibility, deferring instead to medical expert opinion. Post-*Bolitho*, Teff questions the circumstances in which expert evidence might be disregarded.¹⁶⁹ Lord Browne-Wilkinson's reference to 'logic' might focus narrowly on internal consistency and credibility of the expert. Conversely, 'use of the term logic may be seen as a residue of deference, not to be understood in any unduly constraining sense in future cases',¹⁷⁰ in which case there is scope for judges to question the substantive content of the decision.

In 2018, the Court of Appeal took a restrictive stance, setting a high standard for a claimant to satisfy: except in stark cases, expert evidence will usually be required to demonstrate illogicality.¹⁷¹ Nonetheless, wider application of *Montgomery* principles of partnership and patient-centred practice might require HCPs to negotiate the 'schools of thought in medical science'¹⁷² with the patient in mind. If so, then there are grounds upon which to argue that HCP-centred practice is illogical and untenable in those rare cases that alternative 'schools of thought in medical science' apply, but the identification of treatment options or constructive knowledge of risk flows from 'divergent attitudes among doctors as to the degree of respect owed to their patients'.¹⁷³

In this section, it has been argued that commitment to the *Montgomery* principles of autonomy and partnership would lead to gradual extension of the patient-centred *Montgomery* approach by analogy. Even where *Bolam* applies, the relevance of *Montgomery* to the *Bolitho* gloss has been established in *ARB* and is likely to lead to other instances where processes that do not comply with *Montgomery* principles are challenged.

167. Op. cit., [18].

168. *Birch v. University College London Hospital NHS FT* [2008] EWHC 2237 (QB).

169. H. Teff, 'The Standard of Care in Medical Negligence – Moving on from *Bolam*?', *Oxford Journal of Legal Studies* 18(3) (1998), p. 473.

170. Op. cit., 481.

171. *Williams v. Cwm Taf Local Health Board* [2018] EWCA Civ 1745, [14] (Underhill LJ).

172. *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11, [84].

173. Op. cit.

Conclusion

The emphasis on HCP-centred medicine in *Bolam* has gradually been undermined by social and legal developments,¹⁷⁴ but we have set out two ways in which the *Bolam* legacy remains relevant when judging the adequacy of medical advice. First, *Montgomery* only goes so far in challenging the pervasive nature of *Bolam*. Inherent limitations flow from reference in *Montgomery* to consumerism and there are practical impediments to *Montgomery's* application. As the Cumberlege report¹⁷⁵ recently exemplified, paternalistic behaviour is still commonplace. In extending the relevance of a patient-centred approach beyond the law of non-disclosure of material risk, we have argued that it is important to manage consumeristic patient expectations. HCPs have a legitimate role in limiting recourse to treatment options that are not clinically indicated.

Second, *Bolam* retains doctrinal relevance. Lord Diplock warned in *Sidaway* that the dissection of negligence would be neither meaningful nor practical. We have argued that the dissection was a meaningful and relevant response to the ethical requirement to challenge medical dominance over the law, but we have acknowledged and described difficulties as to practicability and coherence. The division of negligence is in part a distinction between treatment and diagnosis on the one hand and information and advice on the other. It is in part a distinction according to the relevance of medical expertise and patient values. As we have seen, the different explanations do not always align. The focus on medical expertise is not a principle of law, but a practical distinction based on the fact that diagnosis and treatment are more likely to raise technical questions.¹⁷⁶ Where medicine is less technical in nature, or where patient values are pertinent to the decision, judges may show increasing willingness to question the clinical view whether through direct application of *Montgomery* or the development of the *Bolitho* gloss.

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174. Op. cit., [75]–[81].


175. Baroness Cumberlege (Chair), *First Do No Harm*, 2.13–2.24.

176. See Australian cases demonstrating the same issue: *Howarth v. Adey* [1996] 2 VR 535, p. 547 takes the former approach and *Ainsworth v. Levi*, unreported, New South Wales Court of Appeal, 30 August 1995, the latter.

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